

“Open the Other Eye”: Payment, Civic Duty and Hospital Contributory Schemes in Bristol, c.1927–1948

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Introduction

On the appointed day of 5 July 1948, the National Health Service (NHS) came into existence in Britain. What existed before had been a complex and constantly evolving mixed economy of healthcare, within which hospital services were provided by a combination of public and voluntary sectors. The public sector accounted for the majority of hospital beds and dominated treatment of the chronic and aged sick. However, it is the voluntary hospitals that have often been seen as at the heart of this system because of their historic foundations—many having been established as charitable institutions in the eighteenth and nineteenth centuries—as well as their perceived clinical superiority.¹ In fact, the move towards a national health service, which ultimately nationalized the hospitals, gave great credence to an approach Daniel Fox has described as “hierarchical regionalism”. This placed such institutions as leading specialist and teaching centres at the top of a hierarchy of regional service providers, and in doing so reinforced this view of the primacy of the voluntary hospitals.²

From their foundations in the mid-eighteenth century, both general and specialist voluntary hospitals across Britain expanded dramatically in the nineteenth century. However, the early twentieth century saw them struggling to maintain their financial foothold in the shifting sands of the mixed economy, and historians have typically seen this period as something of a fall from grace for the voluntary hospitals, with demands and costs rapidly increasing and deficits becoming commonplace.³ This was perhaps most evident in the aftermath of the First World War. During wartime, the voluntary sector had been part of a wide-scale co-ordination of hospital services under the direction of the War Office. Indeed, Geoffrey Finlayson has commented that, in the process, “Voluntarism

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¹ Robert Pinker, *English hospital statistics, 1861–1938*, London, Heinemann, 1996, p. 2.

² Daniel M Fox, *Health policies, health politics: the British and American experience, 1911–1965*, Princeton University Press, 1986. See also Martin Powell, ‘Hospital provision before the National

Health Service: a geographical study of the 1945 Hospital Surveys’, *Soc. Hist. Med.*, 1992, 5 (3): 483–504.

³ David Owen, *English philanthropy, 1660–1960*, Cambridge, MA, Belknap Press of Harvard University Press, 1964, pp. 525–72; Martin Gorsky, John Mohan and Martin Powell, ‘The financial health of voluntary hospitals in interwar Britain’, *Econ. Hist. Rev.*, 2002, 55 (3): 533–57, pp. 542–6; Richard M Titmuss, *Problems of social policy*, London, HMSO, 1950, pp. 256–7; Harry Eckstein, *The English health service: its origin, structure, and achievements*, Cambridge, MA, Harvard University Press, 1958, pp. 72–5.

itself became—almost—collectivized”.⁴ Bristol was very much part of this trend, with the Bristol Royal Infirmary’s King Edward VII Memorial Wing serving as the headquarters for Southern General No. 2, the region’s wartime grouping of public and voluntary hospitals.⁵ This successful wartime policy left in its wake a financial crisis for those hospitals involved, key to which was the £530,000 shortfall the King’s Fund famously calculated in the government’s reimbursement of the voluntary hospitals in London alone.⁶ This formed a significant element of a growing and “palpable crisis” in voluntary hospital funding at the time, which Martin Gorsky, John Mohan and Martin Powell have judged to be the only “genuine threat to the system”.⁷ It was one which saw the overdraft of the Bristol Royal Infirmary, financially the strongest of the city’s major voluntary hospitals, increased in less than two years from £17,985 to more than £42,125 by the end of 1920.⁸

Although such financial troubles were common, recent views have tended to be more generous, although very few have been as positive as David Green’s overtly political assessment of the pre-NHS voluntary sector as a “galloping horse”.⁹ Certainly the sector’s provision was increasing over the interwar period, alongside the growing demands of technology, wages and consumer costs such as food prices, as well as patient numbers.¹⁰ The response to these changing circumstances was a search for new and greater income. This process, which has been seen as defining the voluntary hospitals in the early twentieth century, has been most accurately described as one of “diversification”.¹¹ This meant that traditional sources of charitable income were accompanied by new and expanded alternatives, such as public funds and payments. It is to payments from two sources, directly from patients, and via hospital contributory schemes, to which we now turn.

Contribution in Context

Historically, admission to a voluntary hospital in Bristol had been largely dependent upon support from one of the institution’s philanthropic donors.¹² This changed in 1921, when three of the city’s largest voluntary hospitals introduced a new system of patient payments, under which admission remained essentially a clinical decision but the patient was expected to make a financial contribution of 21s per week towards the cost of his

⁴ Geoffrey Finlayson, *Citizen, state, and social welfare in Britain, 1830–1990*, Oxford, Clarendon Press, 1994, p. 198.

⁵ For the situation in Bristol, see Martin Gorsky, “‘For the treatment of sick persons of all classes’: the transformation of Bristol’s hospital service, 1918–1939”, in Peter Wardley (ed.), *Bristol Historical Resource* (CD-ROM, UWE Bristol, 2001), 2.3; George Campbell Gosling, “‘Co-operate! Co-ordinate! Unify!’” The 1920 proposal to amalgamate the medical charities of Bristol’, *Southern Hist.*, 2007, **29**: 89–106, pp. 88–9; Bristol Record Office (hereafter BRO), 35893/2.r, Bristol Royal Infirmary (hereafter BRI), General Committee Minutes, 1918–26, 11 Nov. 1919.

⁶ F K Prochaska, *Philanthropy and the hospitals of London: the King’s Fund, 1897–1990*, Oxford,

Clarendon Press, 1992, p. 81; Owen, op. cit., note 3 above, p. 236.

⁷ Gorsky, Mohan and Powell, op. cit., note 3 above, p. 535.

⁸ BRO, 35893/5.g-h, BRI Finance Committee Minutes, 1916–20 and 1920–3.

⁹ David Green, ‘Medical care without the state’, in Arthur Seldon (ed.), *Re-privatising welfare: after the lost century*, London, Institute of Economic Affairs, 1996, pp. 21–38, on pp. 33–4.

¹⁰ Gorsky, Mohan and Powell, op. cit., note 3 above, pp. 542–6.

¹¹ *Ibid.*, p. 554.

¹² For more detail, see George Campbell Gosling, ‘The patient contract in Bristol’s voluntary hospitals, c.1918–1929’, *University of Sussex Journal of Contemporary History*, 2007, **11**: 1–16, pp. 4–5.

or her maintenance.¹³ However, these payments cannot be considered fees. An important distinction was made “between payment for maintenance and payment of the staff”.¹⁴ On announcing the new system, the *Bristol Times and Mirror* explained: “These payments, it should be clearly understood, are not for medical services—which will be given gratuitously as hitherto, thanks to the generous spirit of the medical staffs—but solely as a contribution toward the cost of maintenance.”¹⁵ Additionally, they were not demanded of all patients. “The contribution is not compulsory and no patient who is financially unable to make a contribution is asked to do so. The scheme . . . has been carried out in such a considerate way that it does not bear hardly on any patient.”¹⁶ So wrote the almoner of the Bristol Royal Infirmary in the scheme’s first year. It was her job (it was almost always a “Lady Almoner”) to ensure the scheme’s “considerate” implementation. Before 1921 hers had been the task of assessing patients’ circumstances to see if they should be asked to make a donation to the hospital.¹⁷ With the new payment scheme her role was inverted, as she had to assess the circumstances of patients to judge whether they might not be able to make the payment, and should instead receive some reduction or wholesale exemption.

Such exemptions were high in the scheme’s first full year, with 56 per cent of patients at the Infirmary admitted without any payment, and a further 17 per cent making a contribution at a reduced rate.¹⁸ At the Bristol General Hospital it continued to be common for half of all patients to be classified as “unable to pay”, and a further fifth to pay at a lower level throughout the interwar period.¹⁹ The fact that this was a response to the circumstances of patients was highlighted by the Infirmary’s almoner, who stated: “Both in the in-patient and out-patient departments a very large proportion of cases are passed as entirely free. As long as poverty and unemployment exist this will always be the case and it is well to emphasize the fact.”²⁰ Although the share of patients paying nothing decreased during the 1920s it rose again in the early 1930s, “due chiefly to the severe depression prevailing amongst the various industries . . . and unemployment”.²¹ However, throughout these ebbs and flows, such exemptions and reductions at the city’s two general voluntary hospitals would always cover a majority of patients.²²

There was an alternative path to exemption from these payments, and that was membership of a hospital contributory scheme. These groups were mutual societies, which operated by taking a contribution of, typically, two or three pence per week from their members and in return paying any hospital fees asked of them. Further definition can be somewhat elusive, not least because of their varied origins. Some developed out of charitable Hospital Saturday and Sunday collection funds, others were rooted in workplace collections, and

¹³ For more details, see *ibid.*, pp. 5–8.

¹⁴ BRO, 35893/8.d, BRI Faculty Minutes, 20 Nov. 1919; BRO, 40530/A/1(a)3, Bristol General Hospital (hereafter BGH), Board Minute Book and Election Committee, 1913–1938, p. 27.

¹⁵ *Bristol Times and Mirror*, 2 July 1921, p. 7.

¹⁶ BRI annual report for 1921, p. 10.

¹⁷ For an introduction to the origins of the hospital almoner system including the role of the Charity Organisation Society, see Lynsey Cullen, ‘The first lady almoner: the appointment, position and findings

of Miss Mary Stewart at the Royal Free Hospital, 1895–1899’, paper given to the Voluntary Action History Society’s seminar series at the Institute of Historical Research, London, on 28 Sept. 2009, available as an online podcast at www.history.ac.uk.

¹⁸ BRI annual report for 1922, p. 21.

¹⁹ BGH annual reports for 1922–1938.

²⁰ BRI annual report for 1922, p. 21.

²¹ BRI annual report for 1932, p. 18.

²² BGH annual reports for 1922–1938; BRI annual reports for 1924–1940.

in some cases one or more hospitals actually established schemes directly.²³ Schemes in different areas also adopted a wide variety of policies. For example, some schemes—often seen as forerunners of the NHS—pushed for an “open door” policy, whereby, once they had provided the funding, treatment was universal and free at the point of use.²⁴ Meanwhile, others adopted a style more like that of commercial insurance.²⁵ This has led to a debate over whether the schemes were charitable or insurance organizations.

Steven Cherry has seen them as pivotal in a radical break from the philanthropic traditions of the voluntary hospital system, offering a “non-deferential” means of accessing their services and bringing about a “quasi-insurance” system.²⁶ Indeed, some schemes promoted themselves implicitly as insurance schemes, including one Bristol scheme which encouraged people to “anchor” themselves to the organization for financial security (see Figure 1), and another which described membership as “A First-Class Investment for a Rainy Day!”²⁷ However, hospital contributory schemes also played a major fundraising role beyond covering the payments of their members. In the case of one Bristol scheme, grants towards the general maintenance of the hospitals matched those payments on behalf of their members.²⁸ In other words, their financial relationship with the city’s voluntary hospitals was 50 per cent insurance, 50 per cent fundraising, which mirrors the “dual thread of self-interest and humanitarianism” found in London by Gorsky, Mohan and Willis.²⁹

This system, however, was not a universal one. The general wards of voluntary hospitals were subject to income limits, which restricted the admission of those below middle-class levels of income. As can be seen from Table 1, the British Medical Association recommended a system by which those with higher incomes but with dependents would also be granted admission to the general wards. Although there were exceptions, such as emergency cases, the presence of income limits restricted middle- and upper-class patients to the hospitals’ private wards. In 1879 Henry Burdett condemned the lack of such provision in English hospitals, advocating the introduction of an American-style system of “medical lodgings”.³⁰ Over the later years of the 1920s, Bristol saw the introduction of private wards. By the end of the decade, the Infirmary had nineteen beds in sixteen “paying wards”, where patients were charged at a weekly rate of £5 5s or £8 8s for double and single wards respectively.³¹ These private patients also had to “pay a reasonable fee to members of staff”, which

²³ See Martin Gorsky and John Mohan, with Tim Willis, *Mutualism and health care: British hospital contributory schemes in the twentieth century*, Manchester University Press, 2006, pp. 19–43. See also Barry Doyle, ‘The politics of voluntary care in Middlesbrough, 1900–1948’, in Anne Borsay and Peter Shapely (eds), *Medicine, charity and mutual aid: the consumption of health and welfare in Britain, c.1550–1950*, Aldershot, Ashgate, 2007; and Steven Cherry, ‘Hospital Saturday, workplace collections and issues in late nineteenth-century hospital funding’, *Med. Hist.*, 2000, **44**: 461–88.

²⁴ Gorsky and Mohan, op. cit., note 23 above, p. 139.

²⁵ Steven Cherry, ‘Accountability, entitlement, and control issues and voluntary hospital funding c.1860–1939’, *Soc. Hist. Med.*, 1996, **9** (2): 215–33.

²⁶ Cherry, op. cit., note 23 above, p. 462; *idem*, ‘Beyond national health insurance: the voluntary hospitals and hospital contributory schemes: a regional study’, *Soc. Hist. Med.*, 1992, **5** (3): 455–82, p. 455.

²⁷ Bristol Contributory Welfare Association private archive (hereafter BCWA), BMICS annual report for 1937, inside back cover.

²⁸ BCWA, BMICS annual report for 1934, p. 6; annual report for 1929, pp. 8–9.

²⁹ Mohan and Gorsky, op. cit., note 23 above, p. 109.

³⁰ Henry C Burdett, *Pay hospitals and paying wards throughout the world: facts in support of a rearrangement of the English system of medical relief*, London, J & A Churchill, 1879.

³¹ BRO, 35893/8.d, BRI, Faculty Minutes, 29 June 1926.

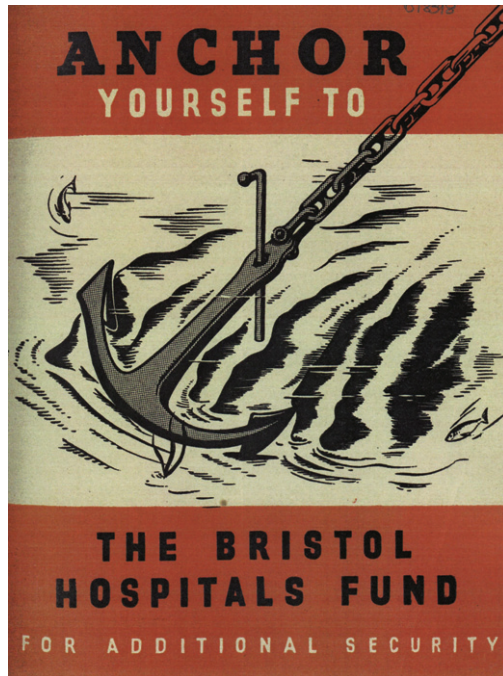


Figure 1: “For additional security”.
(Source: Bristol Hospitals Fund, annual report for 1946, front cover.)

Table 1
BMA recommended income limits for voluntary hospital general wards, c.1926

Class	Limit	Open to
1	£200	a) single persons over 16 b) widow or widower without children under 16
2	£250	a) married couples without children under 16 b) persons with one dependant under 16
3	£300	a) married couples with a child or children under 16 b) persons with more than one dependant under 16

(Source: BSC, DM980 (30), Bristol Hospitals Commission 1941, BHF evidence, appendix 1.)

the faculty decided should be a contribution towards a staff fund rather than a payment to an individual physician.³²

Although such private provision doubled over the 1930s, it remained a marginal aspect of voluntary hospital services.³³ This was true across England, with the middle-class

³² *Ibid.*, 16 Feb. 1927; 4 June 1928.

³³ The number of pay beds for middle-class patients was best recorded in *The Hospitals*

Year-Books, London, Central Bureau of Hospital Information, 1933–1939.

12 per cent of the population receiving only 7.6 per cent of voluntary hospital beds.³⁴ This was even more pronounced in Bristol, where between 15 and 20 per cent of the population had only 4.2 per cent of voluntary hospital beds.³⁵ Despite this, the hospital contributory schemes felt it necessary to cater for this group. Thus, the schemes had income limits corresponding with those of the voluntary hospitals, and increasingly in the later 1930s and the 1940s they developed secondary provident schemes, open to middle-class contributors, covering the cost of admission to the private wards along with a range of other benefits. As such, the mechanics of admission to pre-NHS voluntary hospitals and hospital contributory schemes were designed upon the principle of class differentiation. Different services were provided on different terms to different sections of society.

A parallel development was taking place in municipal provision. Indeed, this was a period of great reform in public hospitals. At the beginning of the twentieth century, public hospital provision was made by local authorities, who, after 1871, provided isolation hospitals for the treatment of infectious diseases, and under the Poor Law, where, after 1885, the destitute sick were treated without the penalty of disenfranchisement. Although such hospital care has been suggested as the “origins of the National Health Service”,³⁶ recently historians have focused on 1929 as the turning point. The Local Government Act of that year sought to end the Poor Law by transferring its responsibilities for welfare to the Public Assistance Committees, and those for medical care to the Public Health Committees.³⁷ In doing so, it aimed to classify the sick poor simply as patients rather than paupers. Local authorities were empowered to “appropriate” Poor Law infirmaries into municipal general hospitals for the community as a whole.³⁸ In Bristol, it became a “flagship policy” to appropriate the Southmead Infirmary, and on 1 April 1930 control of the hospital was transferred and it became the city’s only municipal general hospital.³⁹ However, it was not open to all on equal terms. A Ministry of Health survey in 1932 reported on the category of “paying patients”: “There are 10 single wards available for such patients at £3.3.0 a week; if treated in the general wards the fee is £2.2.0. In 1929 there were 133 private patients admitted; in 1930 there were 21 and in 1931 the number rose again to 78.”⁴⁰ These ten beds in private wards accounted for less than 1.5 per cent of the hospital’s total 672 beds.⁴¹ As such, it was a marginal provision, but is worth noting because it was more common for such hospitals

³⁴ According to John Stevenson, *British Society 1914–1945*, Harmondsworth, Penguin, 1984, p. 119, in 1938 the Ministry of Labour conducted investigations into family income and found that 88 per cent of the population had incomes below £250 per annum. Usefully, this is also the level at which an individual would typically be above the general ward income limits for a voluntary hospital and he would, therefore, have to seek treatment in a private ward or elsewhere.

³⁵ Gorsky and Mohan, *op. cit.*, note 23 above, p. 74; Charles Madge, ‘The propensity to save in Blackburn and Bristol’, *Econ. J.*, 1940, **50**: 410–48, p. 411.

³⁶ Ruth Hodgkinson, *The origins of the National Health Service: the medical services of the New Poor Law, 1834–1871*, Berkeley, University of California Press, 1967.

³⁷ Alys Levene, Martin Powell and John Stewart, ‘The development of municipal general hospitals in English county boroughs in the 1930s’, *Med. Hist.*, 2006, **50**: 1–28, p. 4.

³⁸ See Alys Levene, Martin Powell and John Stewart, ‘Patterns of municipal health expenditure in interwar England and Wales’, *Bull. Hist. Med.*, 2004, **78**: 635–69, pp. 644–6.

³⁹ National Archives, Kew (hereafter NA), MH 66/1068, Allan C Parsons, *County borough of Bristol: survey report*, 1932, p. 129. See also Gorsky, *op. cit.*, note 5 above, 4:3 and 3:4; Gosling, *op. cit.*, note 12 above, pp. 89–90.

⁴⁰ Parsons, *op. cit.*, note 37 above, p. 142.

⁴¹ *Ibid.*, p. 135.

to treat all patients in the same wards, and to take payments from them for either part or all of the cost of maintenance according to their circumstances.⁴² Under those arrangements, it can be seen that most appropriated municipal general hospitals had the equivalent of a voluntary hospital general ward, but Southmead offers an example where they had an equivalent private ward as well.

The compulsory fees for the private wards of the voluntary hospitals, like those of their municipal counterparts, make the motivation for middle-class contributory scheme membership clear. However, the motivation of working-class members, who would be exempted from payments if unable to afford them, is less obvious. It is suggested here that there were two factors encouraging working-class contribution. The first was a widespread confusion regarding the patient payment system introduced in 1921, almoners reporting for years afterwards that there was a prevalent but mistaken idea that payment was compulsory.⁴³ This surely led some people to turn to contributory schemes as a form of insurance. However, with exemptions as high as they were, it would be unrealistic to think this view was held by all those who contributed. The second was a message promoted publicly by those associated with the schemes in the city that contribution was a civic duty. This is a theme that will be returned to in some detail. First, however, some contextualization will be provided by means of an overview of the situation regarding hospital contributory schemes in Bristol.

Competition and Consensus

Contributions from working people had been recorded as a source of income from 1884, and this expanded after the First World War.⁴⁴ Reflecting this, such contributors were represented on the Works Governors' Committees of the Bristol Royal Infirmary, the Bristol General Hospital and the Cossham Memorial Hospital, although there is little to suggest they played any significant role in the governance of these institutions. The number of these representatives was determined by the size of their donations and they were, therefore, dominated by the groups located at the larger employers of the city, including the Wills tobacco manufacturers, the Fry confectioners and the Bristol Tramways and Carriage Company.⁴⁵ However, it was smaller private works funds, donating less than £100 each year, which provided the majority of industrial income to the hospitals. This typically totalled around £5,000 per annum at the larger hospitals, which was between 10 and 20 per cent of all ordinary income.⁴⁶

Throughout the early 1920s, however, membership of these industrial schemes did not equate to an exemption from the general ward patient payment system. Rather, the medical faculty were committed to the notion that the only distinctions between patients should be medical ones.⁴⁷ They insisted it was a matter of principle that "preferential treatment is not given to any patients", despite the protestations of the local contributing firm, J S Fry and Sons, that "some scheme should be devised whereby those who contribute to the Infirmary

⁴² See NA, MH 66, Ministry of Health: Local Government Act 1929, Public Health Survey.

⁴³ BRI annual report for 1925, pp. 19–20.

⁴⁴ Gorsky and Mohan, *op. cit.*, note 23 above, pp. 25–31.

⁴⁵ University of Bristol Special Collections (hereafter BSC), DM980 (28), Contributory schemes

conference dinner 1942, letter from Mr Dodd of the Bristol Hospitals Fund to Alderman Hyde of the Nuffield Provincial Hospitals Trust, 1942.

⁴⁶ BRI annual reports for 1924–1940; BGH annual reports for 1922–1938.

⁴⁷ BRO, 35893/8.d, BRI, Faculty Minutes, 8 Dec. 1919.

Funds should have priority over those who make no contribution".⁴⁸ The momentum for a change in this position appears to have built up during the middle of the decade, while hospital governors were considering the development of a public contributory scheme along the lines of the pioneering Sheffield penny-in-the-pound scheme, which had been established in 1922.⁴⁹ In 1926, representatives of Bristol's voluntary hospitals met and agreed their own model for a contributory scheme. They decided, firstly, to organize a campaign encouraging increased charitable donations to the hospitals; secondly to expand the organization of the Works Committees to ensure that all local works funds would be represented; and thirdly to establish a "Central Association" to cover "small bodies of workpeople who are unable to adopt a scheme for themselves".⁵⁰

The following year the Bristol Medical Institutions Contributory Scheme (hereafter the BMICS) was founded, and the opposition to exempting contributors from general ward payments was dropped. Although it was the founding objective of the BMICS to operate alongside the existing public works funds, many of the smaller industrial schemes disappeared in the following decade. Indeed, the number of works funds contributing to the Bristol General Hospital fell from over 400 in the early 1920s to 98 in 1938.⁵¹ However, the larger private works funds continued operating and making a valuable contribution. For example, the Wills fund remained the biggest single source of income at the Bristol Eye Dispensary until the inception of the NHS in 1948.⁵² Although the level of income from the BMICS in the 1930s has been criticized by both contemporaries and historians,⁵³ it is worth noting that the combined income of the BMICS and the works funds grew enough to keep their proportion of overall hospital income roughly consistent as it increased through the interwar years.⁵⁴ This was the result of a collaborative co-existence between the BMICS and many of the workplace schemes, which was cemented in 1940 with the establishment of the Bristol Hospital Contributors League.⁵⁵ The year before, however, a new organization had been established in the city, with which the BMICS had a very different relationship.

John Dodd had arrived in Bristol in 1937. He had previously been assistant secretary and then secretary of the Merseyside Hospitals Council, where he was successor to Sydney Lamb, who had earlier established the much-admired Sheffield scheme.⁵⁶ In Bristol he was appointed financial adviser to the Bristol Royal Infirmary and Bristol General Hospital, where he was given responsibility for reforming and increasing contributory income. His initial proposal was that the BMICS be remodelled to bring it into line with its Sheffield and Liverpool counterparts. This would involve bringing the independent workplace schemes under the control of the BMICS so that it would be the only scheme in the city, creating

⁴⁸ BRO 35893/2.v, BRI House Committee Minutes, 4 Sept. 1919.

⁴⁹ BRO, 35893/2.r, BRI General Committee Minutes, 21 April 1925. See Steve Sturdy, 'The political economy of scientific medicine: science, education and the transformation of medical practice in Sheffield, 1890–1922', *Med. Hist.*, 1992, **36**: 125–59, pp. 144–5.

⁵⁰ BSC, DM980 (30), Bristol Hospitals Commission (hereafter BHC) 1941. Evidence submitted by the Bristol Hospitals Fund (hereafter BHF evidence), appendix 1.

⁵¹ BGH annual reports for 1922–1938.

⁵² Bristol Eye Dispensary annual reports for 1931–1947.

⁵³ For an example of contemporary criticisms, see BSC, DM980 (35), draft letter from the BHF to the Associated Voluntary Hospitals, 1939, p. 2; for an example of the historical critique, see Gorsky, *op. cit.*, note 5 above, 3:4.

⁵⁴ BRI annual reports for 1924–1940; BGH annual reports for 1922–1938.

⁵⁵ BSC, DM980 (30), BHC 1941. BHF evidence, appendices 22 and 29.

⁵⁶ Gorsky and Mohan, *op. cit.*, note 23 above, p. 103.

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a single decision-making body on which hospital representatives rather than contributors would have a majority, allowing them to insist that the rates of members' contributions and the level of payment to the hospitals should both be substantially increased.⁵⁷ Such reforms were opposed on a number of grounds. There were concerns that raising the rate of contribution would cause hardship to "the single old age pensioner".⁵⁸ The BMICS considered it "a basic principle that the people who provide the money are entitled to decide the manner of its distribution" and so supported the continued dominance of the committee by the contributors.⁵⁹ Furthermore, it was felt important to maintain the independence of the smaller schemes, located as they were at the grass-roots of working-class civil society.⁶⁰

Although the BMICS offered a series of practical concessions in January 1939,⁶¹ these were rejected in favour of maintaining a commitment to the principle of unifying the schemes, an agenda explicitly influenced by the politics of the planning movement.⁶² Dodd and the hospitals then adopted a new approach to the implementation of the same agenda. In July of that year they established a new contributory scheme directly controlled by the hospitals with the intention of having every other scheme in Bristol affiliated. The Bristol Hospitals Fund (hereafter the BHF) and the BMICS with its Contributors League were now at the head of opposing camps as outright competition broke out, and a struggle to set the course for the development of the contributory movement in the city ensued. This resulted in a stalemate that was resolved only by the introduction of the NHS a decade later, which undermined the primary function of the schemes.

This is not to say that the establishment of the BHF brought about no improvements. In financial terms, it surpassed its founding objective of raising an extra £60,000 per year to "bridge the gap" of the hospitals deficits (see Figure 2) in its first few years.⁶³ Although it should be noted that the revenue it raised, which never reached as much as £100,000 in any one year, compared poorly with the nearly £300,000 raised by the Merseyside Hospitals Council in 1941, the almost £500,000 by the Birmingham Hospital Contributory Association, or the £1 million by the Hospital Saving Association in London.⁶⁴ However, the impact of the BHF reached beyond the funds it raised directly, as the rivalry it instigated appears to have been to some degree constructive. For example, the pressure asserted by the BHF convinced the BMICS to raise both its rates of contribution and its rates of payment to the hospitals in 1945.⁶⁵ Meanwhile, the BHF's desire to amalgamate with the independent schemes in opposition to the BMICS led to their acceptance of majority contributor control in 1943.⁶⁶

Concessions on both sides were matched by innovations. On the part of the BHF, a system of local depots was introduced where individuals not contributing at their workplace

⁵⁷ BSC, DM980 (30), BHC 1941. BHF evidence, appendix 3.

⁵⁸ BCWA, annual report for 1939, p. 8, and annual report for 1940, p. 8.

⁵⁹ BSC, DM980 (30), BHC 1941. BHF evidence, appendix 9.

⁶⁰ *Ibid.*, appendices 22 and 29.

⁶¹ BCWA, 30s historical file, Communication from the Joint Committee of Hospital Representatives to the BMICS.

⁶² John Dodd, 'Co-ordination of contributory schemes: a subject of considerable importance today',

Hospital and Nursing Home Management, Nov. 1942, pp. 53–4.

⁶³ Bristol Hospitals Fund (hereafter BHF) report for 1939–1941.

⁶⁴ BSC, DM980 (3), Council members BDC, Divisional Council, Chairman's File, no. 1, 'Notes on the future of hospital services', 1941, p. 3.

⁶⁵ BSC, DM980 (41), Miscellaneous files 2, Bristol and District Divisional Hospitals Council, Contributory Scheme Costs and Receipts, 1942–1944.

⁶⁶ BHF annual report for 1943, p. 3.

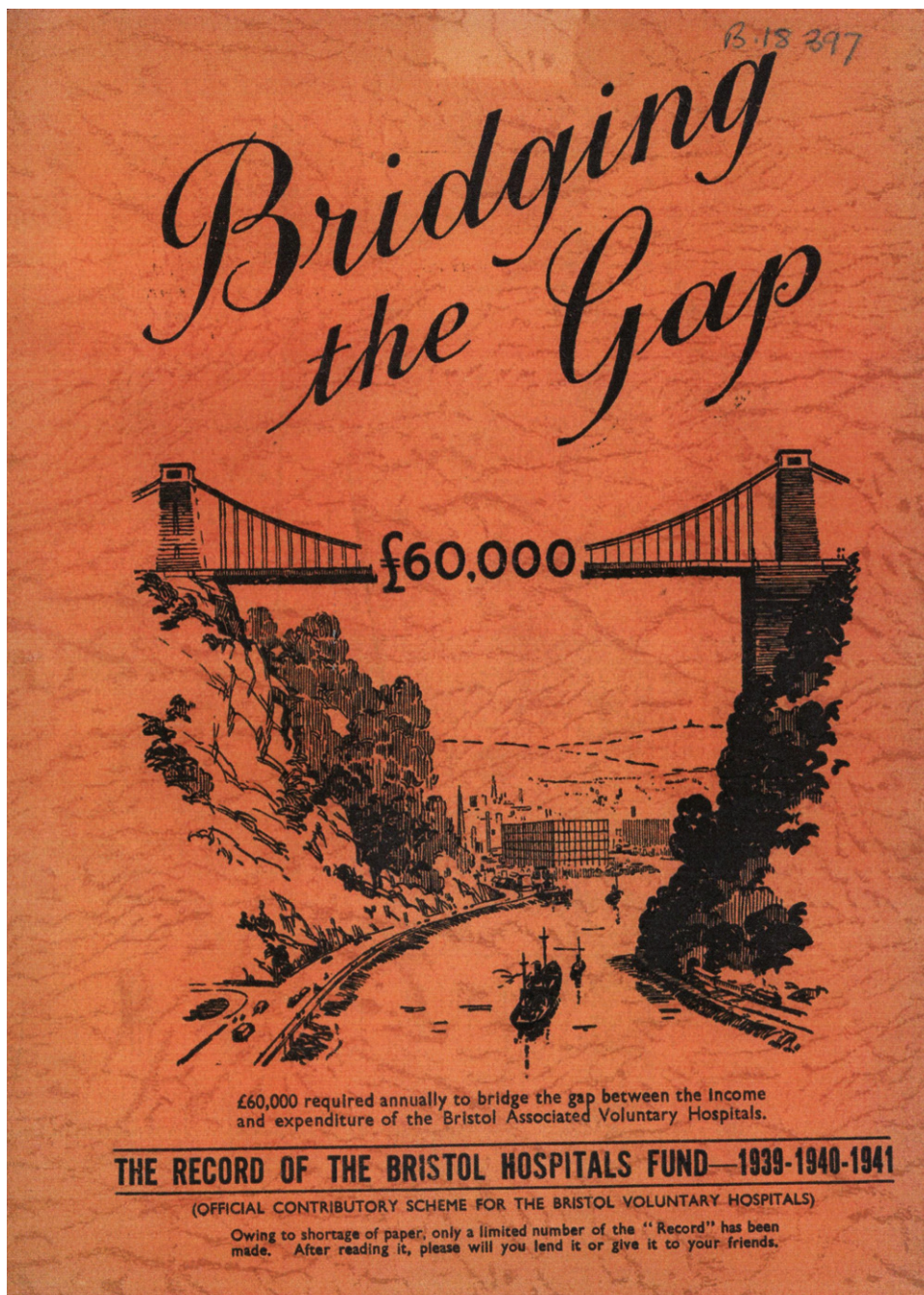


Figure 2: "Bridging the gap".
(Source: Bristol Hospitals Fund, report for 1939–1941, front cover.)

could buy hospital stamps which entitled them to contributor benefits.⁶⁷ Between July and September 1939 forty-eight depots were established, thirty-three in Bristol, two in Kingswood, six in Somerset and seven in Gloucestershire.⁶⁸ Meanwhile, in opposition to the BHF agenda of unification, the BMICS grouped together with sixteen smaller schemes to form the Contributors League, allowing for more co-ordinated collaboration than had previously been the case.⁶⁹

Alongside these competitive innovations there was a degree of unspoken consensus on the question of the range of services to be provided by the schemes. In 1930, the BMICS had introduced its "Section 2". This was its middle-class scheme, "established to assist those who normally, owing to income limits, are not eligible for treatment in the public wards of the Voluntary Medical Institutions", allowing them "to become [patients] in a private ward".⁷⁰ Costing one or two guineas per year (depending on whether the contributor alone would be covered or their family as well), the scheme also offered grants-in-aid of up to 10 guineas per year towards hospital expenses for the contributor, his wife and dependants under the age of eighteen. In contrast, the working-class scheme had no grants-in-aid, and only covered dependants up to the age of sixteen and only then when they were not working themselves.⁷¹

A third BMICS scheme, this one constitutionally and legally separate, was set up in 1935. This was the Extended Benefits Scheme, which offered cash benefits to contributors when they were admitted to hospital, as well as additional surgical services and convalescent home care.⁷² The BMICS was proud that this new scheme was "the first of its kind in the United Kingdom", and it has been considered a pioneer by historians (since most contributory schemes in the 1950s operated cash grants schemes).⁷³ However, in the 1930s the scheme was controversial, with the BMICS called upon to justify it at annual general meetings of the British Hospital Contributory Schemes Association (hereafter the national association) in both 1936 and 1937. In response, the BMICS's founding Honorary Secretary, Mr J S Tudor:

... maintained that this matter was entirely outside the province of the Contributory Scheme Movement, as the accounts were separated from those of the ordinary Contributory Scheme, and that the Scheme was being managed by a committee which had no jurisdiction of the Committee of The Bristol Medical Institutions Contributory Scheme and vice versa.⁷⁴

The hospitals were not reassured and became increasingly resentful of this scheme, claiming cash benefits to patients to be "inimical to the interests of the Voluntary Hospitals", and this became a key disagreement as the relationship between the BMICS and the voluntary hospitals broke down almost entirely.⁷⁵ Despite Section 2 being separated from the BMICS

⁶⁷ BSC, DM980 (35), Outline of proposals for the establishment of the BHF, June 1939, p. 2, and letter from the Bristol Hospitals Fund to the six associated hospitals.

⁶⁸ BSC, DM980 (35), BHF Committee Minutes, 21 Sept. 1939.

⁶⁹ BSC, DM980 (30), BHC 1941, BHF evidence, appendices 22 and 29.

⁷⁰ BCWA, BMICS annual report for 1932, inside front cover; annual report for 1930, p. 4; annual report for 1944, pp. 1–2.

⁷¹ BCWA, annual report for 1930, p. 2.

⁷² BCWA, annual report for 1934, inside front cover; '30s historical' file, rules adopted, Dec. 1936.

⁷³ BCWA, annual report for 1935, p. 5; Gorsky and Mohan, *op. cit.*, note 23 above, p. 196.

⁷⁴ BCWA, '30s historical' file, 'At the 24th Meeting of the Executive Committee of the British Hospitals Contributory Schemes Association', 17 July 1936.

⁷⁵ BSC, DM980 (30), BHC 1941. BHF evidence, 'Communication from the Joint Committee of Hospital Representatives to the Bristol Medical Institutions Contributory Scheme (Inc.)'.

and merged with the Extended Benefits Scheme as the Bristol Contributory Scheme Welfare Association on 1 January 1940, leaving the BMICS as a more traditional contributory scheme,⁷⁶ there was a general dissatisfaction amongst the hospitals with the BMICS. Indeed, hospital representatives went as far as to suggest changing “its name to Bristol Welfare Association in order that it is completely dis-associated [*sic*] in the minds of the public from hospital contributory schemes”.⁷⁷

The perception that the BMICS was more an insurance body than a hospital fundraiser was reinforced by the rhetoric that had been present since its foundation. Indeed, the scheme’s first president, Mr Brookhouse Richards, had stated that its objective, as well as raising funds for the hospitals, was “to assist those unable to afford it to have the treatment without burdening themselves, their families, or the hospitals. That was not charity, but pure common sense, which ought to appeal to every thinking man and woman”.⁷⁸ Likewise, the Dean of Bristol was quoted as saying of the BMICS: “Here is something to enable the man not so fortunately placed as other men, for some small contribution to take away something that will free his mind of any thought of big expenses, if illness comes along . . . Surely this is one of the best forms of insurance that has ever been started.”⁷⁹

It appears to have been this thinking, rather than that of the hospitals, which held sway at the BHF, for it directly mimicked these initiatives. In 1941, the BHF founded its Intermediate Contributory Scheme, which mirrored the BMICS’s Section 2 in covering those above the set income limits for private ward costs, and which had been planned from the BHF’s inception.⁸⁰ Similarly, the Welfare Fund was an imitation of the BCSWA’s cash benefit scheme, established when the latter decided in 1943 to restrict membership to members of the BMICS. The very fact that the BHF felt “obliged to create a separate Welfare Fund” demonstrates that, in this case, outright competition for contributors forged a consensus over what services ought to be provided.⁸¹

Despite this trend for increasingly insurance-style services from both the BMICS and the BHF, both remained organizations firmly rooted in the voluntary sector. On a superficial level, the illustration cover of the BHF’s 1945 report portrays the various insurance-style schemes as contributing to success in fundraising (see Figure 3). In terms of fundraising it is noteworthy that within two years of operating, the BMICS had placed over 1,000 collection boxes within ten miles of the city centre.⁸² In addition to which, from 1931, charitable donations from individuals or workpeople’s funds could be earmarked for specific institutions.⁸³ Perhaps most significantly, while most of the BMICS’s income would always come from employees and individual contributors,⁸⁴ its expenditure was not limited to covering patient payments; in fact, grants on average accounted for half of BMICS payments to hospitals, which were for specific causes such as the Royal Infirmary’s Cancer Research Fund as well as general annual grants.⁸⁵

⁷⁶ BCWA, BMICS, 1939 report, p. 4.

⁷⁷ BSC, DM980 (28), Contributory Schemes Conference dinner 1942, Bristol and District Divisional Hospitals Council, schedule 2.

⁷⁸ BCWA, BMICS annual report for 1928, p. 7.

⁷⁹ BCWA, BMICS annual report for 1936, p. 6.

⁸⁰ BHF, report for 1939–1941, pp. 6, 9–10; BSC, DM980 (30), BHC 1941. BHF evidence, appendix 7.

⁸¹ *Ibid.*, DM980 (35), Bristol Hospitals Fund (unnamed file), ‘Summarised diary of negotiations to establish One Central Hospitals Contributory Scheme in Bristol’.

⁸² BCWA, BMICS annual report for 1928, p. 8.

⁸³ BCWA, BMICS annual reports for 1931–1945.

⁸⁴ BCWA, BMICS annual reports for 1928–1945.

⁸⁵ BCWA, BMICS annual report for 1934, p. 6; annual report for 1929, pp. 8–9.

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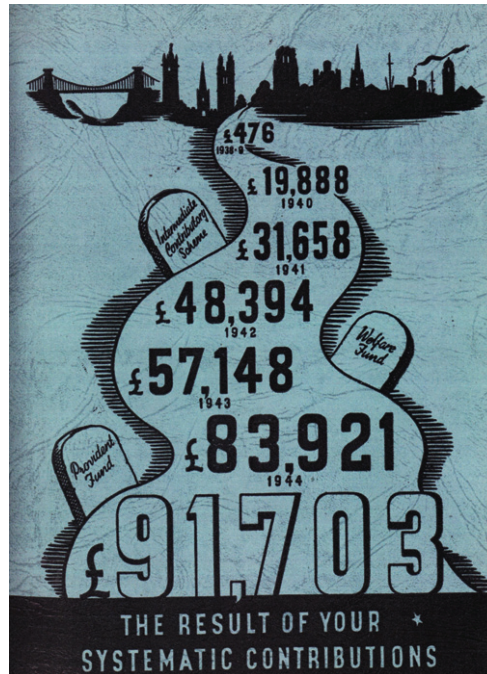


Figure 3: “The result of your systematic contributions”.
(Source: Bristol Hospitals Fund, annual report for 1945, front cover.)

The BHF, similarly, did not deal with contributory income sources alone. It took over the administration of the charitable Lord Mayor’s Fund in 1941,⁸⁶ and under the NHS the insurance service broke away and the BHF remained only to collect and distribute charitable donations for the city’s hospitals.⁸⁷ As such, there was a working solution found to balancing charitable fundraising and increasingly insurance-style services. Given the local rivalry, it is all the more significant that this consensus was reached implicitly by the two major public contributory schemes. Indeed, they also reached a consensus on the idea of contribution being not only an act of enlightened self-interest but also a civic duty.

Contribution as a Civic Duty

The issue of whether the schemes were acting as insurance or charity bodies is an open debate. Key to this is the question of whether members who had paid into a scheme had earned a “right” to hospital treatment if taken ill. Strictly speaking they had not, as the national association made plain, stating that a contributory scheme:

is not an Insurance Scheme, but is a Voluntary Organisation ... Membership of a Contributory Scheme cannot give any right to contributors to admission to any Hospital, nor any priority right

⁸⁶ BSC, DM980 (12), Lord Mayor’s Hospital Fund, B&D DHC Sub-Committee, report of meeting of standing committee sub-committee

and the Lord Mayor’s Fund sub-committee, 16 Nov. 1942.

⁸⁷ BHF annual report for 1947, p. 6.

in regard to order of admission. Questions of admission and of the order of admission are medical questions outside the scope of a Contributory Scheme. . . . The privileges of the Scheme in regard to Hospitals commence to operate after the patient has been admitted to Hospital for treatment, and should be limited to securing for the Contributor immunity from any payment towards cost of maintenance in Hospital. Where the privileges of the Fund are based on income limits, the Contributory Scheme should also secure the Contributor immunity from questions in regard to his or her circumstances.⁸⁸

Despite this, the early twentieth century did see the growth of the expectation of access to healthcare as a right, and contributory schemes have been perceived as pivotal in this development.⁸⁹ This meant significant changes in how patients' rights were understood. They were mirrored by a fundamental shift on the other side of the patient contract: the responsibilities of the patient. Historians have long discussed the essentially subordinate role of the patient as a recipient of medical charity.⁹⁰ Moral judgements of working-class life were caught up with the idea that patients should reciprocate to prove themselves "deserving" of treatment by demonstrating their virtue.

This has been evidenced by Lynsey Cullen's recent work on the first Lady Almoner, Miss Mary Stewart, who was appointed to the Royal Free Hospital in 1895. Following a home visit from this early medical social worker, some patients were refused treatment. Miss Stewart's record book recalls the case of a home visit on which she found "the mother very dirty and untidy, and gossiping in the street". Meanwhile, in another case she considered "the family to bare [*sic*] good character", that they were "sober and hardworking, but very poor". Free treatment was refused in the first case and granted in the second.⁹¹

This showed the almoner to be a defender of the traditional philanthropic brand of moral reciprocalism, where the patient was expected not to transgress certain behavioural codes. However, it was rare for the almoner to suggest individuals be refused treatment. For the most part her role was to assess the circumstances of patients and recommend an appropriate level at which they should be asked to contribute financially to the hospital. The emergence of the almoner profession and the rise of hospital contributory schemes in the early twentieth century represent a fundamental change. Although the two were not mutually exclusive and cannot be seen entirely in isolation from each other, the old principle of moral reciprocalism was giving way to the new economic reciprocalism, which was founded on the notion of earning the right to hospital treatment by means of a financial contribution, as a form of what Finlayson called "citizenship by contribution".⁹²

⁸⁸ BCWA, '30s historical' file, Extracts from BHCSA Points of Policy for Hospital Contributory Schemes, 1937; emphasis in original.

⁸⁹ Cherry, *op. cit.*, note 25 above, pp. 230–1; Gorsky and Mohan, *op. cit.*, note 23 above, p. 108; Doyle, *op. cit.*, note 23 above.

⁹⁰ For example, see Roy Porter, 'The gift relation: philanthropy and provincial hospitals in eighteenth-century England', in Lindsay Granshaw and Roy Porter (eds), *The hospital in history*, London, Routledge, 1989, pp. 149–78, on p. 150; Colin Jones, 'Some recent trends in the history of charity', in Martin Daunton (ed.), *Charity, self-interest and*

welfare in the English past, London, UCL Press, 1996, pp. 51–63; Alan Kidd, 'Philanthropy and the "social history paradigm"', *Soc. Hist.*, 1996, 2: 180–92, pp. 184, 186–7; Mary Fissell, *Patients, power, and the poor in eighteenth-century Bristol*, Cambridge University Press, 1991, pp. 11, 196–7.

⁹¹ Royal Free Hospital Archives, RFH/6/A/1, Almoner's Record Book, pp. 17–19. For further discussion of Mary Stewart, see Cullen, *op. cit.*, note 17 above.

⁹² See Finlayson, *op. cit.*, note 4 above, pp. 9 and *passim*.

Hospital Contributory Schemes in Bristol

The notion of a civic duty to contribute was expressed in a number of ways. It was commonly asserted in general terms as “the primary duty of every good citizen”.⁹³ This message and the schemes themselves, however, were aimed not at every citizen but at the working classes. The London situation offers an example of this, with two major organizations established by the hospital reformer Henry Burdett. One was designed to bring the prestige of royal support to philanthropic fundraising amongst the middle classes. This continues today as the King’s Fund. Meanwhile, the League of Mercy was established a year later in 1898 as an auxiliary of the Fund intended to seek contributions from “the poorer classes”, who, Burdett noted, were least likely to make charitable donations but most likely to use the services of the hospitals.⁹⁴ While this could be seen as a patronizing attitude of the kind that has marred the reputation of charity with historians, it should be noted that all the large Bristol schemes sought to elicit donations from employers as well as their employees. Likewise, the national association defined the key purpose of the schemes as raising funds for the voluntary hospitals “primarily from wage-earners and their employers”.⁹⁵ Indeed, the BMICS’s promotional material suggested it was the duty of a good employer to make such a contribution.⁹⁶ In rhetoric at least, therefore, contribution was seen to be a universal duty.⁹⁷

Richards, founding president of the BMICS, put forward a case for seeing contribution as a civic duty on a number of grounds when he spoke in 1935, declaring:

These great hospitals were founded by the past generation, but what is the present generation doing to maintain them? We know that in our organization and others like it we have 70,000 contributors, but it is computed that at least 40,000 responsible citizens of Bristol do not contribute one penny to voluntary institutions. Yet when the necessity arises they are the first to seek the privileges of the hospitals, being enabled to do so through the self-sacrifice of their neighbours.... It is often said of the people of Bristol that they sleep with one eye open, I ardently desire them to open the other eye, and take stock of the unhappy position that some of the hospitals find themselves in to-day, I would say, Wake up, Bristol, and realize the full extent of your responsibilities.⁹⁸

The philanthropic dimension was likewise emphasized by the Bishop of Bristol on the foundation of the BHF, asserting that the “alleviation of suffering and the curing of disease is much more than the responsibility of the religious community. It is the duty of every citizen.”⁹⁹ Alternatively, on a more personal level, contributing to the fund could be seen as a duty to one’s family (Figure 4). The same approach was taken by Richards when he “suggested to the wives of every wage-earner in the city that they should insist that it was the duty of her husband to her, the children, and himself, to join the contributory scheme, and so abolish all anxiety as to the future in the case of illness”.¹⁰⁰ Meanwhile, contribution

⁹³ BCWA, BMICS annual report for 1931, p. 8.

⁹⁴ Prochaska, *op. cit.*, note 6 above, p. 35; F K Prochaska, ‘Burdett, Sir Henry Charles (1847–1920)’, *Oxford Dictionary of National Biography*, Oxford University Press, 2004.

⁹⁵ BCWA, ‘30s historical’ file, extracts from BHCSA Points of Policy for Hospital contributory Schemes, 1937.

⁹⁶ BCWA, BMICS annual report for 1933, inside back cover.

⁹⁷ BCWA, BMICS 1931 report, p. 8; BSC, DM980 (4), Council Members BDC, Bristol and District Divisional Hospitals Council: Chairman’s File, no. 1, Alderman Burgess’ notes on report of the Aero Engines Ltd Welfare Superintendent, 1942.

⁹⁸ BCWA, BMICS annual report for 1936, p. 4.

⁹⁹ BHF, report for 1939–1941, inside front cover.

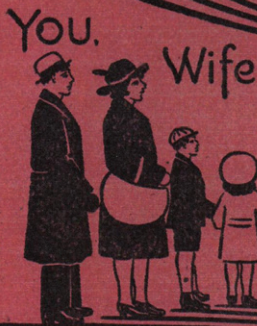
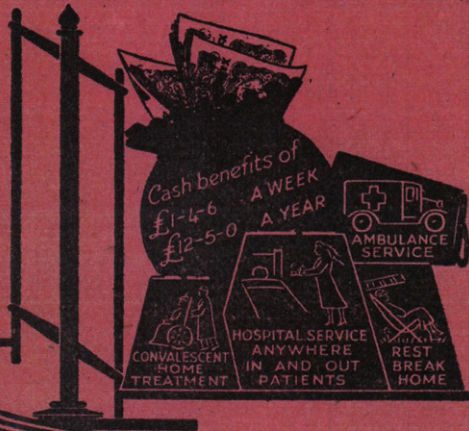
¹⁰⁰ BCWA, BMICS 1928 report, p. 7.

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Figure 4: "It is your duty to them ...".
(Source: Bristol Hospitals Fund, annual report for 1943, back cover.)

Hospital Contributory Schemes in Bristol

was also characterized as a personal responsibility, a means for a “self-respecting citizen” to “pay their way”.¹⁰¹

Evidence that such statements were not just fundraising rhetoric but a voicing of genuinely held values is clear from the reaction when it was believed that patients or schemes had not paid their way. For example, many schemes from different areas had reciprocal arrangements, so that if people fell ill away from home they would still receive the benefits of contribution. The BHF had such an arrangement with a Torquay scheme, although Dodd described their rate of payment to the Bristol hospitals as “absolutely absurd”. During the Second World War he commented:

One would think it impossible for any borough the size of Torquay, even though they have not received much attention from the enemy, to calmly go on as though they have no obligations to their neighbours in these days. I shall certainly tell them what I think of them every time they try and shift their responsibility on to Bristol citizens . . .¹⁰²

Similarly, Herbert Baker, president of the Bristol General Hospital, noted in reference to motor crashes that: “Although some victims were generous, others passing through the city did not pay what they should.”¹⁰³

It is notable that those hospitals in Bristol where contributory schemes were not a factor did not undergo the same cultural-ideological repositioning. This can be seen in the case of the Bristol Temporary Home and Lying-in Hospital. It was not affected by contributory schemes as they did not cover “ordinary maternity cases”, and it stuck to its commitment “to exercise a moral and religious influence over the girls, to help them to regain their own self-respect and that of others”.¹⁰⁴ The continuance of a moralistic premise for admission was reflected in their annual reports, which, up until the 1940s, stated the core mission of the institution, declaring:

The object of the Home is to receive and influence for good young women who are expecting to become mothers for the FIRST time, and who have never mixed with degraded companions; also to place the infants in charge of responsible women, from whose care they cannot be removed without the sanction of the Committee.¹⁰⁵

A similar, although less clear-cut, example is the Orthopaedic Hospital and Home for Crippled Children, which did receive income from contributory schemes, but this generally constituted only between 1 and 2 per cent of ordinary income.¹⁰⁶ Meanwhile, a focus on behaviour was characteristic. While there is a medical angle to promoting their “remedial gymnastics” or “school in the open air”, the equal attention given to “lesson time” in their annual reports suggests the behaviour of patients was a concern in its own

¹⁰¹ BSC, DM980 (30), BHC 1941. BHF evidence, appendix 7. Copies of the *Western Daily Press* and *Bristol Mirror*, 20 July 1939, ‘Bristol voluntary hospitals, contributory scheme inaugurated, fund which will embrace city and district’.

¹⁰² BSC, DM980 (5), letter from Mr Dodd to Alderman Burgess, 14 May 1941; letter from Mr Dodd to Mr Iles of Torbay Hospitals Contributory Scheme, 3 Apr. 1941.

¹⁰³ BCWA, BMICS annual report for 1929, p. 8.

¹⁰⁴ BRO, 37006/R/3/1, Bristol Temporary Home and Lying-in Hospital, annual report for 1908, p. 5; emphasis in the original.

¹⁰⁵ *Ibid.*, annual reports for 1908–1939; emphasis in the original.

¹⁰⁶ BRO, 40536/Adm/R/2/5-6, Orthopaedic Hospital and Home for Crippled Children, annual reports for 1926–1927; 40536/R/4/1-10, Winford Orthopaedic Hospital, annual reports for 1930–1940 and 1944–1947.

right.¹⁰⁷ In both cases, the role of the patient appears to have been understood in socio-behavioural terms, akin to the old-fashioned moral reciprocity. The implication of this is that the fundamental reconfiguration that took place in the patient contract was, in Bristol at any rate, limited to those hospitals where contributory schemes were a significant reality.

There is, furthermore, some evidence that the notion of contribution as a civic duty was held not only by those running the contributory schemes and the voluntary hospitals, but by the working classes as well. While criticizing the pre-BHF schemes, Dodd suggested that the level of membership in Bristol compared poorly with that of other cities. He listed the impressive number of contributors in Sheffield (250,000), Liverpool (332,000) and Birmingham (600,000) in 1937.¹⁰⁸ He did not, however, offer any membership figure for Bristol. Each of these other cities operated a single, central scheme, the membership of which was itself the contributor rate of the city. Bristol was different, for the BMICS operated alongside the myriad of independent workplace schemes. It is, therefore, harder to give a single figure for the city. That said, we can combine the stated membership of the Bristol Hospital Contributors League,¹⁰⁹ which included the BMICS, with the published membership rates of the BHF.¹¹⁰ This suggests the membership rate for Bristol was in the region of 150,000 in the early 1940s. Certainly this is less than those of some major English provincial cities, but comparisons with others, for example the nearby cities of South Wales, show Bristol in a different light. Swansea was the largest scheme in Wales with 114,000 members in 1941, while Cardiff had only 66,000.¹¹¹

A survey of working-class living standards in Bristol was conducted by Herbert Tout in 1937.¹¹² Tout's figures were analysed by Charles Madge, later co-founder of the Mass Observation movement.¹¹³ Given the increased publicity that would come with a public dispute such as that between the BMICS and the BHF, and with the membership drives of both, it is likely that the contributor base increased after these figures were recorded. However, they are still worth noting. It was found that 62.4 per cent of all working-class families contributed to hospital funds, and among families headed by skilled and semi-skilled male labourers, what might be considered the respectable working classes, this percentage rose to 74.3 and 78.5 per cent respectively.¹¹⁴ Given the rate of exemption from general ward payments for those on low incomes, such a high rate of contribution from the city's working classes demonstrates an acceptance that this was their civic duty.

¹⁰⁷ Winford Orthopaedic Hospital, annual reports for 1933–1935.

¹⁰⁸ BSC, DM980 (35), BHF, central contributory scheme memorandum, 1939. The following year, the membership figures differed with 250,000 for the Merseyside Hospitals Council as opposed to the Sheffield Hospitals Council, and 700,000 compared with 600,000 for the Birmingham Hospitals Contributory Association according to Gorsky and Mohan, *op. cit.*, note 23 above, p. 44. Whichever of these figures are the most accurate, they are significantly larger than those for Bristol.

¹⁰⁹ BSC, DM980 (30), BHC 1941. BHF evidence, appendix 22.

¹¹⁰ BHF annual reports for 1939–1948.

¹¹¹ Gorsky and Mohan, *op. cit.*, note 23 above, p. 72.

¹¹² Herbert Tout, *The standard of living in Bristol: a preliminary report of the work of the University of Bristol Social Survey*, Bristol, Arrowsmith, 1938.

¹¹³ Madge, *op. cit.*, note 35 above.

¹¹⁴ *Ibid.*, p. 416.

Conclusions

It appears, therefore, that the notion of contribution as a civic duty was accepted across various levels of society, as well as across the mixed economy of healthcare. Locally, at least, financial arrangements of admission in both voluntary and municipal hospitals provided a system open to virtually all on the basis of medical need and paid for by all on the basis of ability to pay, as indeed in the NHS. Although it was a nationalized model of economic reciprocity which ultimately won out, the principle was the same. The fact that this was to be found in voluntarism, local government and the central state should perhaps not be surprising. For economic reciprocity as a financial expression of civic duty within the framework of welfare rights and responsibilities—essentially a sense that it was fair that the working classes should pay their way—sits well alongside the notions of active citizenship and participation in the idealist thinking documented as late as the 1930s by Jose Harris.¹¹⁵ What is unexpected, and therefore all the more important to recognize, is the implementation of such principles in the voluntary hospitals given their historical reputation as stubbornly conservative institutions.¹¹⁶ Rather than blocking reform, the voluntary sector embraced new arrangements and funding streams that operated a new model of the patient contract built upon economic reciprocity.

Although both voluntary and public hospital systems adopted the principle of economic reciprocity, there was another aspect of the patient contract in voluntary hospitals which the new municipal general hospitals openly sought to end, and that was differentiation between the classes in hospital provision. However, as recent research has reminded us, “[w]e should beware of assuming that the name over the door of a hospital was truly indicative of its usership or quality”.¹¹⁷ Some areas were able to provide a universal service and remove “the undesirable taint of pauperism”.¹¹⁸ Indeed, in an attempt to overcome its reputation as a Poor Law infirmary, the new municipal Southmead Hospital in Bristol developed a range of services that directly mimicked those in the voluntary hospitals. These included developing the institution’s provision of acute medical and outpatient services, fostering a specialism in maternity care with the assistance of the University of Bristol in the appointment of consultants.¹¹⁹ While Birmingham, Bradford and Manchester were able to make a successful conversion to universal provision, other areas failed to do so. Medical services in Public Assistance Institutions in Barnsley, Oldham and Lincoln amongst others were criticized,¹²⁰ and in Stockport it was declared that “the Guardians still reign supreme”.¹²¹ Evidence of second-rate public hospital services for the sick poor in many areas cannot be overlooked.¹²² Furthermore, the presence of private wards in hospitals such

¹¹⁵ Jose Harris, ‘Political thought and the welfare state, 1870–1940: an intellectual framework for British social policy’, *Past and Present*, 1992, **135** (1): 116–41.

¹¹⁶ See Prochaska, *op. cit.*, note 6 above.

¹¹⁷ Alysa Levene, ‘Between less eligibility and the NHS: the changing place of Poor Law hospitals in England and Wales, 1929–39’, *Twentieth Century Br. Hist.*, 2009, **20** (3): 322–45, p. 335.

¹¹⁸ Gorsky, *op. cit.*, note 5 above, 4:3; Levene, *op. cit.*, note 117 above.

¹¹⁹ Gosling, *op. cit.*, note 5 above, pp. 89–90; Gorsky, *op. cit.*, note 5 above, 4:3.

¹²⁰ Levene, *op. cit.*, note 117 above, pp. 332–3.

¹²¹ Ministry of Health Survey Report, Stockport, 1932, NA, PRO MH66/898, cited in Levene, *op. cit.*, note 117 above, p. 446.

¹²² Levene, *op. cit.*, note 117 above, pp. 338–9. See also Anne Crowther, ‘The later years of the workhouse, 1890–1929’, in Pat Thane (ed.), *The origins of British social policy*, London, Croom Helm, 1978, pp. 36–55.

George Campbell Gosling

as Southmead demonstrate that, although not governed by a system of income limits as in the voluntary hospitals, class differentiation could be a reality embedded in the emerging municipal general hospital sector. The rise of economic reciprocalism and the persistence of class differentiation can therefore be considered the two defining features of the patient contract, not only in the voluntary hospitals, but also across the pre-NHS mixed economy of healthcare.